

## **Client Information on Office Practice and Policies**

Welcome! I look forward to getting to know you. These first pages explain a bit about me and address general office practices and policies. If you have other more specific questions, please ask. The other pages provide me with some background information.

***About My Practice and Experience:*** I have been a licensed psychologist practicing in Houston since 1987, and I began work in the mental health field in 1972. I earned my doctorate at The University of Texas at Austin. I also earned a Bachelor's degree in psychology from Texas A&M and a Master's degree in counseling from the University of Maryland. I have been in full-time private practice for more than 10 years. I formerly was the Director of the Family Therapy Program at the Houston VA Medical Center. Prior to that, I was a faculty member at the University of Houston. I maintain faculty affiliations with several universities and the Baylor College of Medicine, and I teach graduate courses in marital and family therapy. I serve as a consultant to numerous organizations including the M.D. Anderson Cancer Center, the Attention Deficit Disorders Association, Emory University, and the Richmond State School. I am a past-president of both the Houston and Texas Psychological Associations.

I provide a range of psychological services including individual, marital/couples, group, and family counseling (i.e., psychotherapy). I specialize in relationship counseling, psychotherapy with men, treating abusive relationships, and in consulting with families who have children with exceptional needs. I offer psychotherapy and educational groups dealing with relationship issues, depression, anger problems, parenting, and other concerns. I also provide psychological testing and assessment for evaluating problems of children and adults.

We will jointly determine the goals of treatment or evaluation for you. I will initially take some history and later make recommendations, as I deem appropriate. I will want to know about your present family as well as about your family-of-origin. I like to include other family members during appointments in order to understand their viewpoints as well. I may refer you to one of my psychotherapy groups, for psychological testing, or to another professional if that appears helpful. I often give assignments (homework) to be done between appointments. Most of our time will be spent in discussion of your situation.

**You May Keep This Page**

### You May Keep This Page

**Contacting Me:** You may leave a voicemail message at 713-623-2110. Please keep in mind that I am generally with clients throughout the day, and I have little time to return phone messages. For that reason, I will be brief during phone calls. Phone calls of more than 15 minutes will be billed at the same rate as for psychotherapy. You may send e-mail to [sbuser@comcast.net](mailto:sbuser@comcast.net) however, please use the telephone to change appointment times because I check voicemail more frequently.

**Time Issues:** Most appointments are scheduled for one hour. I will spend around 45 minutes of that time talking with you. The balance of the time will be spent in dealing with paperwork and similar matters. Group psychotherapy sessions are longer, generally 90 minutes in length. I have morning, afternoon, and evening appointments, but I do not see clients on weekends. I will attempt to schedule your appointment at a time that is convenient for you, but please bear in mind that late afternoon and evening times are my most requested times. I schedule appointments about two weeks in advance. If there is an emergency, I will attempt to squeeze you into my schedule that day.

**Cancellation Policy:** Appointment times are always at a premium, and missed appointments are a major problem because of the difficulty in rescheduling. **If you miss scheduled appointments without informing me at least 24 hours in advance, you will be billed at your normal fee because I will be unable to fill that appointment time.** If you decide to terminate services, please let me know. If you fail to attend two consecutive sessions without notifying me, I will assume that you wish to terminate services.

**Risks of Treatment:** Medicines have side effects-risks that you run when you take that medication. Likewise, there are risks in seeking psychological services. For example, you may initially become more anxious. It is normal to feel reluctant about talking with a stranger about your personal life, but this discomfort will probably lessen as you get to know me. If this is the first time that you have seen a psychotherapist, you may feel greater discomfort. Psychotherapy is intended for basically healthy people who want to improve their lives. People who see me are generally successful persons who seek help in coping with specific issues in their lives such as problems in a relationship, a sense of unhappiness in their lives, difficulties in parenting, or coping with a medical condition. Psychotherapy is a joint effort between the psychologist and the client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as your interactions with family, friends, and other associates. Although most people report benefit from psychotherapy, a minority feel that their condition worsened as a result of treatment. Please discuss your feelings about treatment with me.

### You May Keep This Page

## You May Keep This Page

**Confidentiality and Privacy:** In general, any information you provide to me and to those under my supervision will be released to others only by your written consent. There are certain circumstances, however, when a psychologist is required to disclose confidential information without consent from clients. I will break confidentiality if:

- You are a danger to yourself or others
- You are a minor, elderly, or disabled person and are being abused.
- You have perpetrated abuse against a minor, elderly, or disabled person.
- You had sexual contact with a previous psychotherapist or clergy member.
- You file suit against me for breach of duty.
- You use insurance for payment, and the insurance company requests information about your case.
- A court order or other legal proceedings or statute require disclosure.

In order to be compliant with HIPAA rules, you will be given a separate and more complete statement regarding confidentiality of records.

**Records:** I am required to maintain records of my work with you. These generally take the form of notes that I make during and after appointments, intake information, written information that you give to me, billing information, and any correspondence concerning your case. These records will not be released without your written consent except in the situations described under Confidentiality and Privacy. You may request a copy of your records, but I will charge for their reproduction.

### **Billing Practices:**

**Insurance**—Keep in mind that the limits of coverage for mental health concerns vary widely across companies and plans. Your insurance company may have a “preferred provider list” which offers you a discounted rate for choosing one of the mental health providers from their network. I am a member of some of those plans. In the State of Texas if you are a member of a PPO (Preferred Provider Organization), you may choose to go to someone outside of your network provider list and pay a higher co-pay (the amount you pay out of pocket). If you are a member of an HMO (Health Maintenance Organization), you may only be reimbursed by your insurance plan if you go to providers in your network. You should also be aware that insurance companies generally will not reimburse you for marital counseling. The decision about whether or not to reimburse you for psychological services is made by your insurance company. When you provide me with information about your insurance, one of my staff will determine the exact benefits to which you are entitled.

## You May Keep This Page

### You May Keep This Page

*Payment at the time of service*—Payment is expected at the time services are rendered. If I am a member of your managed care network, you need only pay your co-payment. The balance of your bill will be paid directly to Dr. Buser by your insurance plan. If I am NOT a member of your managed care network, then you must pay the FULL fee, and insurance benefits (i.e., payments) will be sent directly to you. If your portion of the payment for services is not received within 30 days, you may be informed in writing that future services will not be provided, and you may be referred to a community agency or program or other practitioner to continue any needed services. Seriously overdue accounts may be referred to a collection agency.

*Monthly statements*—Each month you will receive a statement indicating appointments during the month, payments received, and your current balance. Please keep in mind that it may take 6-8 weeks before I will begin receiving payment from your insurance company. Your statement will reflect my regular fee unless reduced by our prior agreement. Any discounts to the fee as the result of my being in your provider network will be applied **after** payment is received from your insurance company.

*Fees:* The standard fees for my services are listed below. Contractual arrangements with managed care companies or other entities may reduce these fees. If you feel you are unable to afford treatment, please discuss this with me. I can work with you in a variety of ways to make seeing me affordable.

Initial Office Visit	\$175 per session
Individual Therapy	\$175 per session
Family Therapy	\$175 per session
Group Therapy	varies by group
Psychological Testing	\$175 per hour
Forensic Testimony	\$300 per hour

### You May Keep This Page

**Please Complete This Page**

Consent for Treatment

- I have read, understand, and been given a copy of the Client Information on Office Practice and Policies.
- I have been given a copy of the Notice of Privacy Practices (HIPAA-related)
- I know that I may ask further questions as needed.
- I give my consent to treatment by Dr. Buser.
- If I want to use insurance, I authorize Dr. Buser to file for my insurance and to accept assignment of insurance payment for his services unless otherwise specified above.
- I understand that if I use insurance, Dr. Buser may be required to communicate with representatives of my insurance carrier.
- If my insurance company or managed care company does not cover services, I realize that I am responsible for all fees for services provided.
- If I have any concerns or complaints about my treatment, I understand that I should talk with Dr. Buser regarding them.

Client Signature \_\_\_\_\_ Date\_\_\_\_\_

I further consent to the evaluation and/or treatment of my minor child in my legal custody or guardianship.

Signature of Guardian (if applicable)\_\_\_\_\_ Date \_\_\_\_\_

Signature of Dr. Buser \_\_\_\_\_ Date \_\_\_\_\_

**Please Complete This Page**

**Please Complete This Page**

***Background Information***

Client's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Level of Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Currently a Student? Yes No

(for children) Grade: \_\_\_\_\_ School: \_\_\_\_\_

Currently employed? Yes No

Career Field? \_\_\_\_\_

Who referred you to Dr. Buser? \_\_\_\_\_

May I contact the referral source to thank them? Yes No

Have similar problems occurred before? Yes No

Have you seen a psychotherapist before? Yes No

If yes, who was seen, where, and when? \_\_\_\_\_

How helpful was previous treatment?			
Very Helpful	Somewhat Helpful	Not Very Helpful	Made Things Worse

Has there ever been a psychiatric hospitalization? Yes No

If yes, explain: \_\_\_\_\_

Is the present condition related to employment? Yes No

**Please Complete This Page**

Are there any physical health problems?                      Yes                      No

If yes, describe: \_\_\_\_\_

Is there any disability?    Yes                      No

If yes, describe: \_\_\_\_\_

Please list any medications that you are currently taking:\_\_\_\_\_

\_\_\_\_\_

**Problems You Wish to Discuss**

(place a check by any of the problems you wish to discuss with me)

Communication                      \_\_\_\_\_                      Marital Conflict                      \_\_\_\_\_

Anger Problems                      \_\_\_\_\_                      Anxiety                      \_\_\_\_\_

Depression                      \_\_\_\_\_                      Financial worries                      \_\_\_\_\_

Child Abuse                      \_\_\_\_\_                      Parenting                      \_\_\_\_\_

Alcohol or Substance Abuse                      \_\_\_\_\_                      Violence in the Relationship                      \_\_\_\_\_

Sexual Problems                      \_\_\_\_\_                      Traumatic Events                      \_\_\_\_\_

Medical Issues                      \_\_\_\_\_                      Employment/Career \_\_\_\_\_

Infidelity/Affairs                      \_\_\_\_\_                      Suicidal Thoughts                      \_\_\_\_\_

Problems with the Family-of-origin                      \_\_\_\_\_                      Behavior problems of kids                      \_\_\_\_\_

Other: \_\_\_\_\_

**Please Complete This Page**

**Please Complete This Page**

Have you ever felt you ought to cut down on your drinking?	Yes	No
Have people annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of the hangover?	Yes	No
Do you ever feel bad about your use of drugs?	Yes	No
Has drug abuse ever created problems for you in your family?	Yes	No
Have you every been ticketed for driving under the Influence?	Yes	No

When is the last time you were intoxicated? \_\_\_\_\_

**Adult Clients Please Complete This Page**

Number of Marriages: \_\_\_\_\_

Current Marital Status:    Single            Married            Living with Someone  
   Separated            Divorced            Widowed

Name of Current Spouse/Partner: \_\_\_\_\_

(if married) Date of marriage: \_\_\_\_\_

(if living with someone) Since? \_\_\_\_\_

(if separated) Since? \_\_\_\_\_

(if divorced) Date of divorce: \_\_\_\_\_

(if widowed) Since? \_\_\_\_\_

(if currently single):            Never married?            Yes            No  
   In a relationship?            Yes            No

**Important Previous Relationships**

Name of ex: \_\_\_\_\_ Together from: \_\_\_\_\_ to \_\_\_\_\_

Married?            Yes            No

Briefly, why did the relationship end? \_\_\_\_\_

Name of ex: \_\_\_\_\_ Together from: \_\_\_\_\_ to \_\_\_\_\_

Married?            Yes            No

Briefly, why did the relationship end? \_\_\_\_\_

Name of ex: \_\_\_\_\_ Together from: \_\_\_\_\_ to \_\_\_\_\_

Married?            Yes            No

Briefly, why did the relationship end? \_\_\_\_\_

**Adult Clients Please Complete This Page**





**Please Complete This Page**

Insurance Information

Please Check One:

I will not be using insurance. \_\_\_\_\_

I am unsure about using insurance. Please call me. \_\_\_\_\_

If Dr. Buser is on my plan, I will use insurance. \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Insurance Group #: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

Insurance Claim Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

FOR OFFICE USE ONLY

Deductible: \_\_\_\_\_

Annual Calendar Maximum: \_\_\_\_\_

Copay: \_\_\_\_\_

Limitations: \_\_\_\_\_

Lifetime Maximum: \_\_\_\_\_

Other: \_\_\_\_\_